

Intake Date _____

Case # _____

CHILD INTAKE INFORMATION

Patient Name: _____ DOB: _____ Age: _____ Sex: _____

Address: _____

Street City State Zip

School: _____ Grade: _____

Parent/Guardian: _____

Please circle: Mother/Guardian Age Father/Guardian Age

Parent's Address if different: _____

Steparent(s) that live with child (if applicable): _____

Phone (Home): (____) _____ Parent/Guardian (Work): (____) _____

Other: _____
Father/Guardian
(____) _____
Mother/Guardian

Father/Guardian Present Employer: _____

Occupation: _____ Soc. Sec. #: _____

Driver's License #: _____

Mother/Guardian Present Employer: _____

Occupation: _____ Soc. Sec.# _____

Driver's License #: _____

Please circle form of payment: Cash Insurance

Primary Insurance Policyholder's Name Relationship Policyholder DOB

Contract Number Group Number Policyholder's Employer Policyholder SSN

Secondary Insurance Policyholder's Name Relationship Policyholder DOB

Contract Number Group Number Policyholder's Employer Policyholder SSN

It is important to HVCC to be responsive to our patients' needs and your feedback is very useful to us. Please rate the timeliness of scheduling your first appointment:

Excellent Good Fair Poor Very Poor
5 4 3 2 1

****FOR STAFF USE ONLY****

**DSM-IV _____ Code _____

Therapist Signature _____ Therapist Code _____

Print Name: _____

| Insurance | Deductible | Copay | Yearly maximum | Lifetime max |
|-----------|------------|-------|----------------|--------------|
| Primary | | | | |
| Secondary | | | | |

If applicable:
Authorization #: _____ Number of sessions: _____ Dates covered: _____

Please briefly state why this child was brought to the clinic. What are your concerns?

Has your child been seen by any other persons for this problem? Please explain. _____

Education and School History

Please provide the following information for all schools that the child has attended:

| School | Year started | Year stopped | Graduated? |
|--------|--------------|--------------|------------|
|--------|--------------|--------------|------------|

What is your child's attitude about school? About the teacher(s)? About other students? _____

How would you describe your child's performance and behavior at school? Are there any problems?

Financial Status

Family's overall financial status (including gross annual income, major assets/liabilities, number of dependents, etc.): _____

Developmental History

How would you describe the pregnancy with this child? _____

Were there complications? If so, explain: _____

Birth weight: _____

Were there any difficulties in infancy with (please circle):

| | | |
|----------------------------|-----|----|
| Feeding | Yes | No |
| Weight gain | Yes | No |
| Sleeping | Yes | No |
| Weaning from breast/bottle | Yes | No |
| Crying | Yes | No |

When did your child first (age):

| | |
|----------------------|-------|
| Sit | _____ |
| Walk | _____ |
| Say a word | _____ |
| Say simple sentences | _____ |

Describe and give age of any significant illnesses, including ear infections, high fevers, operations, and/or accidental injuries: _____

Describe any problem behaviors or personality difficulties as a preschooler: _____

Has your child had any traumatic or potentially traumatic experiences? If so, explain: _____

During the past year, have there been any significant events which might have had a negative effect on your child? If so, explain. _____

Legal Problems

Does the family have any pending legal problems? Yes No

Have you had prior legal problems in any way associated with your seeking treatment for your child at this time? Yes No

If yes to either of the above, please explain: _____

Culture, Ethic, and Religious Information

Does your family or your child currently, or have you or your child in the past, practiced a particular religion?

Yes No

If yes, please provide additional information about the religion, your current level of involvement, and your anticipated interest in this in the future: _____

Does your family identify with particular cultural or ethnic groups? Of what overall importance is this in your family's life? _____

Present Family Constellation

Names/Ages/Sex of Siblings. Please indicate if any siblings reside in other than the child's residence.

| | | | | | |
|-------|-------|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

Please list any other persons living with the family: _____

Have there been any significant separation, divorces, deaths, etc., in the child's life? _____

Activity Assessment

Approximately how much time does your child spend on play and leisure activities on a typical week day? _____ hours per day.

Approximately how much time does your child spend on play and leisure activities on a typical weekend (Saturday and Sunday?) _____ hours per day.

Is the amount of leisure time your child has available (check one):

Less than adequate _____ Adequate _____ More than adequate _____ Much too much _____

With regards to the ways your child spends leisure time, would you say your child is (check one):

Very dissatisfied _____ Less than satisfied _____ Satisfied _____ More than satisfied _____ Very satisfied _____

Please list the activities in which your child is most active, starting with the activity in which he/she spends the most time? Include activities such as homework, individual or group play, chores, church activities, watching TV, computer, household projects, etc.)

| Activity | Approximate number of hours per week |
|-----------------|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |

Are there activities you would like to see your child involved in? _____

Are there activities your child has expressed interest in, but is not presently involved in? _____

Medical History

Name, address, and phone number of current or most recent medical doctor: _____

What was the date of your child’s last physical examination? _____

Height: _____ Weight: _____

Please list all current medications:

| Name of medication | Dose | Frequency taken | How long taken | Who prescribes |
|--------------------|------|-----------------|----------------|----------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please check “yes” or “no” to indicate whether or not your child uses the following non-medical or non-prescribed drugs. For “yes” answers, please indicate usage:

| | Yes | No | How much | How long |
|----------------------------------|-----|----|----------|----------|
| Cigarettes | | | | |
| Sleeping pills | | | | |
| Tobacco | | | | |
| Alcohol | | | | |
| Marijuana | | | | |
| Cocaine, crack | | | | |
| Inhalants | | | | |
| Stimulants (e.g., “uppers”) | | | | |
| Aspirin or other pain medication | | | | |
| Cold remedies, cough medicine | | | | |
| Coffee | | | | |
| Tea | | | | |
| Cola | | | | |
| Other: | | | | |

Does your child have physical pain? Yes _____ No _____
 If yes, please rate the intensity of the pain: 1 (mild) to 5 (severe): _____
 If yes, where is the pain located? _____
 If yes, how does it affect your child’s functioning? _____

Does your child have any allergies? Yes _____ No _____
 If yes, to what are they allergic? _____

Please check either “yes” or “no” to indicate whether or not the family has any of the following health problems. (Any unanswered questions will be considered a “no” response.)

| | Child | Mother | Father | Siblings | Extended family member |
|--|-------|--------|--------|----------|------------------------|
| Seizure disorder/epilepsy | | | | | |
| Glaucoma | | | | | |
| Emphysema | | | | | |
| Asthma | | | | | |
| Heart trouble | | | | | |
| High blood pressure | | | | | |
| Stomach trouble/ulcers | | | | | |
| Tuberculosis | | | | | |
| Thyroid disease | | | | | |
| Liver disease | | | | | |
| Gall bladder | | | | | |
| Hepatitis | | | | | |
| Diabetes | | | | | |
| Pancreatitis | | | | | |
| Cancer or tumor | | | | | |
| Arthritis or rheumatism | | | | | |
| Alcohol and/or drug abuse | | | | | |
| Stroke | | | | | |
| Anemia | | | | | |
| Depression | | | | | |
| Anxiety | | | | | |
| Mania or bipolar disorder | | | | | |
| Schizophrenia | | | | | |
| Learning disorder | | | | | |
| Attention deficit/hyperactivity disorder | | | | | |
| Other: | | | | | |
| Other: | | | | | |

Is there any other medical, psychiatric, or substance abuse information that you feel we should know?

Is there anything else that you think we should know about your child or your family? _____

Signature:

Parent/guardian

Date

For therapist use only:

If it has been over a year since the child/adolescent’s last physical, did you suggest that the child/adolescent have a physical? Yes_____ No_____ Did the parent/guardian agree to this? Yes_____ No_____

Therapist signature: _____

Date: _____

REV. 807

CHILD/ADOLESCENT SYMPTOM CHECKLIST

Date: _____

Name of the child: _____ Date of Birth: _____ Age: _____

Name of the person completing this form: _____ Relationship to child: _____

Please circle the symptoms that apply to this child in the past few weeks:

| | Never | Rarely | Sometimes | Always | | | | | | | | | |
|-----------------------------------|-------|--------|-----------|--------|---|---|--|---|---|---|---|---|---|
| Hyperactive | 0 | 1 | 2 | 3 | 4 | 5 | Interrupted sleep | 0 | 1 | 2 | 3 | 4 | 5 |
| Fidgety | 0 | 1 | 2 | 3 | 4 | 5 | Early morning waking | 0 | 1 | 2 | 3 | 4 | 5 |
| Difficulty sitting still | 0 | 1 | 2 | 3 | 4 | 5 | Oversleeping | 0 | 1 | 2 | 3 | 4 | 5 |
| Short attention span | 0 | 1 | 2 | 3 | 4 | 5 | Depression | 0 | 1 | 2 | 3 | 4 | 5 |
| Easily distracted | 0 | 1 | 2 | 3 | 4 | 5 | Mood swings | 0 | 1 | 2 | 3 | 4 | 5 |
| Forgets easily | 0 | 1 | 2 | 3 | 4 | 5 | Crying spells | 0 | 1 | 2 | 3 | 4 | 5 |
| Does not turn in assignments | 0 | 1 | 2 | 3 | 4 | 5 | Irritability, edginess | 0 | 1 | 2 | 3 | 4 | 5 |
| Disorganized | 0 | 1 | 2 | 3 | 4 | 5 | Excessive worry | 0 | 1 | 2 | 3 | 4 | 5 |
| Poor grades | 0 | 1 | 2 | 3 | 4 | 5 | Low energy, tired | 0 | 1 | 2 | 3 | 4 | 5 |
| Academically behind | 0 | 1 | 2 | 3 | 4 | 5 | Loss of appetite | 0 | 1 | 2 | 3 | 4 | 5 |
| Learning difficulties | 0 | 1 | 2 | 3 | 4 | 5 | Overeating | 0 | 1 | 2 | 3 | 4 | 5 |
| Speech problems | 0 | 1 | 2 | 3 | 4 | 5 | Weight gain or loss | 0 | 1 | 2 | 3 | 4 | 5 |
| Reading difficulty | 0 | 1 | 2 | 3 | 4 | 5 | If so, how much in the last 3-6 months: Gained _____ Lost _____ | | | | | | |
| Math difficulty | 0 | 1 | 2 | 3 | 4 | 5 | Lack of interest in usual things | 0 | 1 | 2 | 3 | 4 | 5 |
| Defies authority | 0 | 1 | 2 | 3 | 4 | 5 | Difficulty separating | 0 | 1 | 2 | 3 | 4 | 5 |
| Loses temper | 0 | 1 | 2 | 3 | 4 | 5 | Won't sleep in own bed | 0 | 1 | 2 | 3 | 4 | 5 |
| Argumentative | 0 | 1 | 2 | 3 | 4 | 5 | Fears of ordinary things | 0 | 1 | 2 | 3 | 4 | 5 |
| Gets angry easily | 0 | 1 | 2 | 3 | 4 | 5 | For example, storms, crowds, doctor, germs, closed spaces, flying) | | | | | | |
| Gets into fights | 0 | 1 | 2 | 3 | 4 | 5 | Excessive hand washing | 0 | 1 | 2 | 3 | 4 | 5 |
| Throws or breaks objects | 0 | 1 | 2 | 3 | 4 | 5 | Rituals that child must do | 0 | 1 | 2 | 3 | 4 | 5 |
| Problems with temper | 0 | 1 | 2 | 3 | 4 | 5 | For example, need to check and recheck; things in a certain order | | | | | | |
| Homicidal thoughts | 0 | 1 | 2 | 3 | 4 | 5 | Counting behavior, thoughts | 0 | 1 | 2 | 3 | 4 | 5 |
| Suicidal thoughts | 0 | 1 | 2 | 3 | 4 | 5 | Need for organization, cleanliness | 0 | 1 | 2 | 3 | 4 | 5 |
| Suicidal attempts, gestures | 0 | 1 | 2 | 3 | 4 | 5 | Anxiety, nervousness | 0 | 1 | 2 | 3 | 4 | 5 |
| Hurts animals | 0 | 1 | 2 | 3 | 4 | 5 | Panic/anxiety attacks | 0 | 1 | 2 | 3 | 4 | 5 |
| Lies | 0 | 1 | 2 | 3 | 4 | 5 | Headaches | 0 | 1 | 2 | 3 | 4 | 5 |
| Sets fires | 0 | 1 | 2 | 3 | 4 | 5 | Stomachaches | 0 | 1 | 2 | 3 | 4 | 5 |
| Steals, shoplifts | 0 | 1 | 2 | 3 | 4 | 5 | Unexplained physical symptoms | 0 | 1 | 2 | 3 | 4 | 5 |
| Breaks curfew | 0 | 1 | 2 | 3 | 4 | 5 | Dizzy spells | 0 | 1 | 2 | 3 | 4 | 5 |
| Runs away from home | 0 | 1 | 2 | 3 | 4 | 5 | Suspiciousness, paranoia | 0 | 1 | 2 | 3 | 4 | 5 |
| Skips school | 0 | 1 | 2 | 3 | 4 | 5 | Hears voices | 0 | 1 | 2 | 3 | 4 | 5 |
| Smokes | 0 | 1 | 2 | 3 | 4 | 5 | (that others don't) | | | | | | |
| Uses alcohol | 0 | 1 | 2 | 3 | 4 | 5 | Sees things | 0 | 1 | 2 | 3 | 4 | 5 |
| Uses drugs | 0 | 1 | 2 | 3 | 4 | 5 | (that others don't) | | | | | | |
| Legal problems | 0 | 1 | 2 | 3 | 4 | 5 | Wets bed | 0 | 1 | 2 | 3 | 4 | 5 |
| Is or has been on probation | 0 | 1 | 2 | 3 | 4 | 5 | Soils underclothing | 0 | 1 | 2 | 3 | 4 | 5 |
| Is or was in juvenile detention | 0 | 1 | 2 | 3 | 4 | 5 | Eating disorder | 0 | 1 | 2 | 3 | 4 | 5 |
| Problem making or keeping friends | 0 | 1 | 2 | 3 | 4 | 5 | Picky eater | 0 | 1 | 2 | 3 | 4 | 5 |
| Sleep disturbance | 0 | 1 | 2 | 3 | 4 | 5 | Binge-eating, purging | 0 | 1 | 2 | 3 | 4 | 5 |
| Trouble falling asleep | 0 | 1 | 2 | 3 | 4 | 5 | Anorexia | 0 | 1 | 2 | 3 | 4 | 5 |
| | | | | | | | Trauma, other abuse | 0 | 1 | 2 | 3 | 4 | 5 |

Revised 4/05